New Jersey Department of Health and Senior Services

LONG TERM CARE REFERRAL

To	LTCFO	Date
From (CWA/NJEASE Site)	Name of Caseworker	Title
Name of Client		Medicaid No./JACC No.
Client Address		

FINANCIAL INFORMATION

Check appropriate box, indicating date of financial eligibility determination and monthly gross income:

☐ Categorically Eligible Date: _____ Income Amount: _____

☐ Institutionally Eligible Date: _____ Income Amount: _____

DISABILITY INFORMATION

FOR WAIVER PROGRAMS:
Check appropriate box, indicating date of disability determination:

☐ Social Security Date: _____

☐ Disability Review Section Date: _____

CLIENT INFORMATION

Client and Family interested in:

☐ Community-Based Waiver Program Specify Program: _____

☐ JACC

☐ Medicaid Nursing Home Placement

☐ PA-4 Sent ☐ PA-4 Given Date: _____ To: _____

☐ Physician Name: _____

☐ Family Member Name:

Address: _____

_____

Telephone Number: _____

Client's Location at this Time:

☐ Own Home ☐ Assisted Living Facility ☐ Hospital

☐ Relative's Home ☐ Residential Health Care Facility ☐ Nursing Home

☐ Other (specify): _____

Date Admitted: _____ Planned Discharge Date: _____

Address: _____

_____

Telephone Number: _____

Supportive Relative: _____ Relationship to Client: _____

Address: _____

_____

Telephone Number (Work/Home): _____

LONG TERM CARE REFERRAL, Continued

Name of Client	Medicaid No./JACC No.

Client is currently eligible for or receiving:

- ☐ HIC Medicare Number: _____ ☐ Part A ☐ Part B
- ☐ Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program
- ☐ Other Insurance:
  - Name: _____
  - Policy Number: _____
- ☐ Other Governmental Programs (specify): _____
- ☐ Community Services (specify): _____

Complete for Programs:

☐ CCPED ☐ JACC ☐ ECO: _____ ☐ Other (specify): _____

Client/Family have been advised of and clearly understand:			Comments
Overview of Program:	☐ Yes	☐ No	
Financial Eligibility:	☐ Yes	☐ No	
Medical Eligibility:	☐ Yes	☐ No	
Services Available and Limitations:	☐ Yes	☐ No	
No Retroactive Eligibility:	☐ Yes	☐ No	
Cost:	☐ Yes	☐ No	

Other Pertinent Information:
(Family members or other significant persons who request to be present at the assessment; psychological/physical disabilities which would make client interviewing difficult; foreign primary language; where the client wants to receive services; client/family expectation of the long-term care programs)

Signature of Caseworker	Date